

# The Attitudes and Experiences of Trainees Regarding Disclosing Medical Errors to Patients

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## Abstract

### Purpose

To measure trainees' attitudes and experiences regarding medical error and error disclosure.

### Method

In 2003, the authors carried out a cross-sectional survey of 629 medical students (320 in their second year, 309 in their fourth year), 226 interns (159 in medicine, 67 in surgery), and 283 residents (211 in medicine, 72 in surgery), a total 1,138 trainees at two U.S. academic health centers.

### Results

The response rate was 78% (889/1,138). Most trainees (74%; 652/881) agreed

that medical error is among the most serious health care problems. Nearly all (99%; 875/884) agreed serious errors should be disclosed to patients, but 87% (774/889) acknowledged at least one possible barrier, including thinking that the patient would not understand the disclosure (59%; 525/889), the patient would not want to know about the error (42%; 376/889), and the patient might sue (33%; 297/889). Personal involvement with medical errors was common among the fourth-year students (78%; 164/209) and the residents (98%; 182/185). Among residents, 45% (83/185) reported involvement in a serious error, 34% (62/183) reported experience disclosing a serious error, and 63% (115/

183) had disclosed a minor error. Whereas only 33% (289/880) of trainees had received training in error disclosure, 92% (808/881) expressed interest in such training, particularly at the time of disclosure.

### Conclusions

Although many trainees had disclosed errors to patients, only a minority had been formally prepared to do so. Formal disclosure curricula, coupled with supervised practice, are necessary to prepare trainees to independently disclose errors to patients by the end of their training.

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The rise of the patient-safety movement and the publication of the Institute of Medicine report *To Err is Human*<sup>1</sup> have drawn the attention of both the public and physicians to the problem of medical errors. Physicians are increasingly expected to recognize, prevent, and properly disclose medical errors. In particular, ethical standards and guidelines that have emerged from accrediting organizations<sup>2</sup> and professional bodies<sup>3</sup> reflect a movement toward greater transparency in communicating with patients about errors. Although a few schools provide formal instruction in disclosure, these skills are largely taught via the hidden curriculum and role modeling.<sup>4,5</sup> There is little known regarding trainees' attitudes about and experiences with medical errors or their experience in disclosing errors to patients.

Despite the fact that patients uniformly endorse the disclosure of harmful errors,<sup>6,7</sup> such disclosure currently seems to be uncommon.<sup>8,9</sup> Emerging research is shedding new light on the disconnect between expectations that errors will be disclosed to patients and current clinical practice. Recent survey data from practicing physicians highlight their support for the general concept of disclosure and the difficulty they experience actually disclosing errors to patients.<sup>10,11</sup> Although less is known about trainees' attitudes and experiences regarding medical errors and their disclosure, the available literature suggests that most trainees have been personally involved with errors<sup>9,12,13</sup> and that discussing these events with patients presents substantial challenges for residents.<sup>14,15</sup> In one study, 76% of housestaff reported that they had made a serious medical error that they had not disclosed to the patient or a family member.<sup>12</sup>

Academic health centers can enhance transparency in health care by preparing new physicians for the challenges of recognizing and disclosing errors. Like

all accredited organizations, they are also required by Joint Commission regulations to ensure patients are informed about unanticipated outcomes in their care.<sup>2</sup> Improving disclosure and meeting these regulatory goals require understanding how trainees perceive, experience, and disclose errors. Therefore, we undertook a multicenter cross-sectional survey of trainees to explore their attitudes and experiences regarding medical error and error disclosure.

## Method

### Setting and physician sample

Between June and October of 2003, we administered questionnaires to 629 second- and fourth-year medical students (320 and 309, respectively), to 159 interns and 211 residents in internal medicine, and to 67 interns and 72 residents in surgery from two U.S. academic medical institutions: Washington University School of Medicine (in St. Louis, Missouri), and the University of Washington (in Seattle, Washington). These institutions differ in that one (the former) is private and one is public, and

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they are located in two of the 18 U.S. states whose malpractice climates are reported to be “in crisis” because of the very limited availability of affordable professional liability insurance.<sup>16</sup> The questionnaires were distributed to trainees at orientation sessions, conferences, and by e-mail. The results of giving this same questionnaire to physicians in surgery, medicine, and pediatrics have been previously reported.<sup>10,11,17</sup>

**Questionnaire content**

The questionnaire was refined through pilot testing and cognitive interviews. The questionnaire used the Institute of Medicine’s definitions of *adverse event*, *medical error*, and *near miss*.<sup>1</sup> We developed and pilot tested our own definitions of *serious error* and *minor error*. We defined a serious error as an “error that causes permanent injury or transient but potentially life-threatening harm” and a minor error as an “error that causes harm that is neither permanent nor potentially life threatening.” Questionnaire definitions were repeated on every page of the questionnaire, and key terms were capitalized or bolded throughout.

The questionnaire asked respondents about key safety topics, such as whether medical errors are a serious problem and how frequently errors occur. Questions about error disclosure included what types of errors should be disclosed, potential barriers to disclosure, and respondents’ personal experience with medical errors and disclosure. Agreement was measured on a four-point Likert scale (strongly disagree, disagree, agree, strongly agree). Demographic questions measured respondents’ age, gender, and specialty.

**Survey implementation**

This anonymous questionnaire was approved by the institutional review boards at Washington University in St. Louis and the University of Washington. Respondents could complete a paper or Web-based questionnaire. Snacks, soft drinks, and coffee cards were offered as incentives for participation.

**Statistical analysis**

Descriptive statistics included means and standard deviations for continuous variables and percentages for categorical variables. Questions that used four-point

Likert response scales were dichotomized at the midpoint (agree versus disagree). Categorical variables were compared using Pearson chi square, chi square for linear trend, and Fisher exact tests as appropriate. All tests were two tailed, and a *P* value less than .05 was considered significant. We intended the survey to be exploratory, and, therefore, we did not apply a Bonferroni adjustment to the analysis. Comparisons were limited to plausible associations. Analyses were performed using SAS version 9.0 (SAS Institute, Inc., Cary, NC).

**Results**

**Characteristics of respondents**

Surveys were completed by 889 (281 MSII students, 209 MSIV students, 214 interns, 185 residents) of the 1,138 eligible trainees (78%). Of the respondents, 392 (44%) were in training at Washington University and 497 (56%) were from the University of Washington. Interns were more likely to respond than residents (95%, 214/226, versus 65%, 185/283; *P* < .001). The response rate was higher among surgical interns and residents than among medical interns and residents (91%, 126/139, versus 74%, 273/370; *P* < .001). See Table 1 for an overview of the characteristics of the respondents. Not all respondents completed every question, so denominators presented may be lower than the above totals for certain questions. The highest nonresponse rate

for a given question was 2%, and the average nonresponse rate was less than 1%.

**Medical error attitudes and experience**

Most of the medical students (73%, 354/485) as well as the interns and residents (75%, 298/396) agreed that medical error is one of the most serious problems in health care. These respondents also believed that errors are common, although estimates of their frequency varied on the basis of the errors’ severity. Mean estimates of the percentage of hospitalized patients suffering serious errors, minor errors, and near misses were 6%, 20%, and 23% respectively (see Table 2 for the numbers and percentages of trainees who gave these responses). Trainees were divided on the cause of medical errors, with 53% of respondents agreeing and 47% disagreeing that “errors are caused by failures of care delivery systems, not the failure of individuals.”

Personal involvement with medical errors was common among trainees and increased with level of training (trend *P* < .001). By the fourth year of medical school, 79% (164/209) of students reported involvement with errors. Minor errors and near misses predominated (see Table 2). Virtually all residents (98%, 182/185) reported personal experience with errors, with 73% reporting involvement in minor errors and 45% with serious errors. Surgery residents were more likely than their medicine counterparts to have been involved with a

**Table 1**  
**Characteristics of 889 Survey Respondents, Two U.S. Academic Health Centers, 2003\***

Respondent group	No. respondents (no. surveyed)	% who responded	Age (SD)	Men: no. (%)	Women: no. (%)
2nd-year medical students	281 (320)	88	25.4 (3.0)	123 (45)	153 (55)
4th-year medical students	209 (309)	68	27.5 (3.9)	83 (40)	123 (60)
Medicine interns	151 (159)	96	27.8 (2.7)	79 (54)	67 (46)
Surgery interns	63 (67)	94	28.5 (4.0)	44 (70)	19 (30)
2nd- and 3rd-year medicine residents	122 (211)	58	29.6 (2.8)	72 (61)	46 (39)
2nd- through 5th-year surgery residents	63 (72)	88	31.4 (3.8)	41 (66)	21 (34)
Total, all groups	889 (1,138)	78	27.5	442 (51)	429 (49)

\* The authors surveyed the groups of trainees listed above to measure their attitudes and experiences regarding medical error and error disclosure. (Responses do not sum to 891 across all categories if respondents selectively omitted demographic data.)

Table 2

**Attitudes and Experiences of 889 Trainees Regarding Medical Error, Two U.S. Academic Health Centers, 2003\***

Question and error categories†	Statistics, of the types indicated after each question	2nd-year medical students	4th-year medical students	Medicine interns	Surgery interns	2nd- and 3rd-year medicine residents	2nd- through 5th-year surgery residents
<b>For every 100 hospitalized patients, how many will experience a . . .</b>							
Mean no. (SD) patients							
Near miss	23 (20)	27 (24)	19 (18)	23 (20)	22 (19)	22 (18)	24 (20)
Minor error	20 (17)	23 (20)	16 (16)	21 (17)	23 (20)	16 (13)	20 (15)
Serious error	6 (8)	8 (11)	4 (4)	6 (8)	6 (5)	4 (5)	5 (5)
<b>Which medical errors have you personally been involved with?</b>							
No. (%) responding "Yes"							
Near miss	359 (40)	23 (8)	94 (45)	76 (50)	40 (63)	78 (64)	48 (76)
Minor error	392 (44)	32 (11)	99 (47)	82 (54)	44 (70)	90 (74)	45 (71)
Serious error	171 (19)	8 (3)	31 (15)	29 (19)	20 (32)	45 (37)	38 (60)
<b>The following error should be disclosed to Patients . . .</b>							
No. (%) responding "Agree"							
Near miss	235 (27)	93 (33)	48 (23)	41 (27)	18 (29)	22 (18)	13 (21)
Minor error	742 (84)	243 (87)	174 (85)	125 (83)	56 (89)	98 (80)	46 (74)
Serious error	875 (99)	277 (99)	204 (99)	151 (100)	63 (100)	118 (97)	62 (100)
<b>Have you ever disclosed the following error to a patient?</b>							
No. (%) responding "Yes"							
Minor error	233 (27)	7 (3)	60 (29)	41 (28)	10 (16)	82 (68)	33 (52)
Serious error	92 (11)	1 (<1)	9 (4)	15 (10)	5 (8)	37 (31)	25 (40)

\* The authors surveyed the groups of trainees listed above to measure their attitudes and experiences regarding medical error and error disclosure.

† *Near miss* = an error that could have caused harm but did not, either by chance or timely intervention; *minor error* = error that causes harm that is neither permanent nor potentially life-threatening; *serious error* = error that causes permanent injury or transient but potentially life-threatening harm.

serious error (60%, 38/63 versus 37%, 45/122;  $P = .002$ ).

**Error-disclosure attitudes**

Essentially all trainees (99%) agreed that serious errors should be disclosed to patients. A majority of trainees (84%) also felt that minor errors should be disclosed, although this attitude decreased slightly with level of training (Table 2; trend  $P = .031$ ). A minority (27%) believed that near misses should be disclosed, an attitude that also declined with level of training (Table 2; trend  $P = .003$ ).

**Error-disclosure experience**

A third of the residents (34%, 62/183) reported ever disclosing a serious error to a patient. The percentage of trainees who

had disclosed a serious error increased with level of training (Table 2; trend  $P < .001$ ). There was no statistically significant difference between the percentage of surgery and medicine residents who had disclosed a serious error (40% versus 31%,  $P = .23$ ). A total of 63% (115/183) of the residents had disclosed a minor error. Medicine residents were more likely than their surgery colleagues to have disclosed minor errors (68% versus 52%,  $P = .034$ ).

Among residents who had disclosed serious errors, the majority (84%, 67/80) were satisfied with how the conversation went. Few of the residents who had disclosed serious errors (13%) felt the disclosure discussion negatively affected

their relationship with the patient. Similarly, when disclosing minor errors, 94% (154/163) of interns and residents expressed satisfaction with conversations, and only 3% of interns and residents recounted the disclosure having a negative impact on their relationship with the patient.

**Risks of error disclosure**

The majority of trainees (76%, 668/884) agreed that disclosing serious errors decreased the risk of litigation (Table 3). Trainees who had previously disclosed a serious error shared this attitude with those who had not disclosed a serious error (81%, 75/93 versus 75%, 581/775;  $P = .22$ ). About half of the trainees (49%, 438/887) were concerned that "disclosing

Table 3

**Barriers to Error Disclosure Reported by 889 Trainees, Two U.S. Academic Health Centers, 2003\***

Statement and associated possible responses <sup>†</sup>	Statistics, of the types indicated after each statement						
	2nd-year medical students	4th-year medical students	Medicine interns	Surgery interns	2nd- and 3rd-year medicine residents	2nd- through 5th-year surgery residents	
<b>Disclosing a serious error would . . .</b>							
No. (%) responding "Agree"							
Damage a patient's trust in my competence	438 (49)	151 (54)	102 (49)	88 (58)	28 (44)	57 (47)	12 (19)
Make it less likely that the patient would sue me	668 (75)	186 (66)	164 (79)	116 (77)	53 (84)	92 (77)	54 (86)
Be very difficult	813 (92)	264 (94)	195 (94)	143 (95)	54 (86)	110 (90)	47 (75)
<b>It might make me less likely to disclose a serious error if I think . . .</b>							
No. (%) responding "Agree"							
The patient would not understand what I was telling him/her	525 (59)	150 (54)	131 (63)	90 (60)	35 (56)	83 (68)	36 (57)
The patient would not want to know about the error	376 (42)	126 (45)	97 (46)	57 (38)	16 (40)	56 (46)	15 (24)
I might get sued	297 (33)	122 (43)	67 (32)	43 (29)	22 (35)	36 (30)	7 (11)
The patient is unaware an error happened	266 (30)	95 (34)	64 (31)	47 (31)	16 (25)	30 (25)	14 (22)
The patient would be angry with me	159 (18)	64 (23)	39 (19)	23 (15)	10 (16)	21 (17)	2 (3)
I didn't know the patient very well	140 (16)	32 (11)	32 (15)	19 (13)	9 (14)	33 (27)	15 (24)

\* The authors surveyed the groups of trainees listed above to measure their attitudes and experiences regarding medical error and error disclosure.

<sup>†</sup> *Serious error* = error that causes permanent injury or transient but potentially life-threatening harm.

a serious error would damage a patient's trust in my competence." However, trainees who had previously disclosed a serious error were less likely to agree that disclosure would reduce patients' trust than trainees who had not done so (24%, 23/94 versus 53%, 408/777;  $P < .001$ ).

### Barriers to error disclosure

Despite agreeing that serious errors should be disclosed, 87% (774/889) of the trainees acknowledged at least one factor that might make them less likely to do so (Table 3). Although there were no significant variations among interns by specialty, residents in surgery were less likely than those in medicine to report that they might be less likely to disclose if they thought that the patient might be angry (3% versus 17%,  $P = .006$ ), might sue (11% versus 30%,  $P = .005$ ), or might not want to know about the error (24% versus 46%,  $P = .003$ ). The proportion of respondents who reported that possible patient anger or possible lawsuits might make them less likely to disclose errors decreased with level of training (trend  $P = .002$ ,  $P < .001$ , respectively—see Table 3 for the numbers

and percentages of trainees who gave these responses). However, the proportion of trainees who reported they might be less likely to disclose if they didn't know the patient well or thought the patient wouldn't understand what they were telling the patient increased with level of training (trend  $P < .001$ ,  $P = .04$ , respectively—see Table 3).

Nearly all trainees (92%, 813/886) agreed that disclosing a serious error would be very difficult. The 8% (73/886) of all trainees who disagreed that disclosing a serious error would be difficult differed by specialty and level of training from those trainees who agreed with this statement. The view that error disclosure is not difficult was held by surgery residents more commonly than by medical residents (20%, 16/63 versus 7%, 12/122;  $P < .001$ ) and by residents more commonly than by interns (15%, 28/185 versus 8%, 17/214;  $P = .02$ ) or by students (15%, 28/185 versus 6%, 28/487;  $P = .002$ ). Of the 73 trainees who did not feel that disclosing a serious error would be difficult, 80% had not ever disclosed a serious error.

### How trainees were prepared for error disclosure

A minority of students (35%, 169/482) and interns and residents (31%, 120/398) reported ever receiving education or training in error-disclosure techniques. Medicine residents were more likely than their surgery colleagues to have undergone such training (40%, 49/122 versus 24%, 15/62;  $P = .03$ ). Among all trainees, of those who reported disclosing a serious error to a patient, only 41% (38/92) said they had received any disclosure training. A total of 93% of the students and 90% of the interns and residents were interested in receiving general training on how to disclose errors to patients. Similarly, 97% of the students and 95% of the interns and residents were interested in receiving "just-in-time" error-disclosure coaching at the time of a serious error.

### Discussion

To improve the frequency and content of error disclosure as well as to maintain public trust, the next generation of physicians must be prepared to properly disclose medical errors. In this survey,

trainees reported substantial involvement with medical errors, and many reported having disclosed errors to patients. However, this study also suggests that medical students, interns, and residents often perceive significant barriers to disclosing medical errors, which in turn suggests that many trainees will enter practice without adequate error-disclosure skills unless new training programs are implemented. These findings characterize an educational system that misses opportunities to instruct medical trainees on error disclosure.

Consistent with previous smaller studies, we found that the majority of residents and interns reported personal involvement with errors.<sup>11,12</sup> Additionally, a majority of the fourth-year medical students reported involvement in an error, indicating that education on patient safety and error disclosure is important starting early in training. Trainees' perceptions that errors are both common and important suggest they are a receptive audience for patient-safety education.

Although many trainees had disclosed errors to patients, most were not formally prepared for such disclosures. Our data do not allow us to determine whether trainees disclosed errors by themselves or under the guidance of senior clinicians or hospital administrators. Disclosures are extremely challenging discussions, in part because it is often not known whether an adverse event was attributable to an error until formal analyses have been completed. In addition, disclosures are emotionally charged conversations that require advanced communication skills. Thus, many new disclosure guidelines emphasize that it is important for all clinicians, and especially trainees, to obtain help from institutional patient-safety and risk-management resources before undertaking disclosures.<sup>18</sup> Medical educators and institutions should develop and disseminate formal disclosure guidelines regarding the role of trainees in the disclosure process.

Removing trainees entirely from the disclosure process is also undesirable. In our survey, those trainees who reported having disclosed errors to patients had more positive attitudes about disclosure

than did the trainees with no disclosure experience. Trainees who reported having disclosed errors to patients were also generally satisfied with how the conversation had gone, and few reported the disclosure had an adverse impact on their relationship with the patient. These results suggest that formal disclosure curricula along with closely mentored opportunities to disclose errors to patients could provide powerful learning opportunities for trainees.

Trainees universally expressed interest in "just-in-time" disclosure coaching at the time of an error, a prominent feature of new disclosure guidelines.<sup>18</sup> For the most serious errors, such coaching is likely to come from a senior risk manager or medical director. Attending physicians can also play an important role in mentoring trainees in disclosure. The "one-minute preceptor" skills that attending physicians use for teaching clinical medicine can also help provide on-the-fly disclosure education to trainees.<sup>19,20</sup> In addition, attendings can share with trainees their personal experiences of error disclosures that went well and that went poorly, further reinforcing the emerging culture of transparency in medicine. Coaching should include careful planning and rehearsing of the disclosure, helping trainees anticipate likely questions from patients, and formulating appropriate responses. Attendings may well require disclosure training themselves before they are ready to effectively mentor trainees in disclosure.<sup>21</sup> Exploring the current and ideal role that attending physicians play in disclosure by trainees represents an important topic for future study.

Disclosure education for trainees should include not only coaching from attendings but also formal lecture material as well as the opportunity to practice disclosure skills and receive feedback. Simulation using standardized patients may be a valuable tool to provide trainees the opportunity to practice disclosure skills in a consequence-free environment.<sup>22</sup> Disclosure training should be integrated into the broader curriculum on patient safety and error prevention, reflecting emerging national guidelines that recognize disclosure as an integral component of quality improvement.<sup>18</sup>

Although trainees endorsed the principle of disclosing serious errors, nearly 90% reported barriers to doing so, such as concern about patient anger, fear of litigation, and uncertainty whether the patient would want to know about the error. In our prior work, many of these barriers were also identified by attendings.<sup>11</sup> These disclosure barriers might represent useful topics for educators to consider as they design disclosure curricula. Whereas a longitudinal study design would allow firmer conclusions about how medical training affects disclosure attitudes, in the present study trainees' disclosure attitudes generally matured over time in the absence of personal experience with disclosure or formal disclosure training. Through structured interviews with residents, Fischer et al<sup>23</sup> described features of the hidden curriculum, such as the cultural notion of personal responsibility and expectations to practice defensive medicine, that influenced trainees' reactions to medical errors, both positive and maladaptive. However, because many individuals may not have disclosure experience from their training, relying on the hidden curriculum alone to teach effective disclosure skills may result in many physicians' entering practice unprepared for the challenges of disclosing errors to patients.

The first step in the disclosure process is recognizing that a harmful error has occurred. Our data suggest that a gap may exist between trainees' estimates of error frequency and their perceived involvement in errors. Although the residents estimated that near misses and minor errors were common, a significant minority of the residents could not recall ever being involved in either. In a previous study, the authors describe how house officers cope with errors by minimizing and rationalizing, which may help to explain this discrepancy between perceptions and experience.<sup>11</sup> Medical educators might focus on helping residents identify errors in their own work using methods such as resident-driven quality-improvement initiatives or root-cause analysis. Other studies have found that residents can be a resource for error-prevention ideas, suggesting an opportunity for involving trainees not only in error-disclosure training, but also in patient-safety programs.<sup>24,25</sup>

Our survey found that residents and students were split between assigning responsibility for errors to individuals or to health care systems. Although the patient-safety movement has asserted that systems failures underlie the majority of medical errors, the relative contribution of systemic versus individual factors remains a topic of active debate<sup>26</sup> and is an ideal issue to discuss explicitly with trainees in patient-safety curricula. The 80-hour work rules mandated by the Accreditation Council on Graduate Medical Education have forced many inpatient teaching services to adopt rigid shift schedules and shared responsibility for patient care, changes that may generate communication errors.<sup>27</sup> By incorporating a systems approach into the traditional culture of personal responsibility that exists in medicine, academic health centers may turn these challenges in the trainees' environment into opportunities to involve residents in quality-improvement activities.<sup>28</sup>

This study has several limitations. The data came from only two academic health centers, which may limit generalizability. Additionally, this study was cross-sectional rather than longitudinal, limiting our ability to draw conclusions about the effect of training on attitudes over time. Although the response rate was robust, nonresponse bias may have affected the results. Additionally, responses may have been subject to recall bias and social desirability bias. Last, there is no consensus about the role of trainees in disclosure, making it difficult to draw normative conclusions. Despite these limitations, this study represents the largest and most comprehensive investigation to date of trainees' attitudes and experiences regarding medical errors and their disclosure.

In conclusion, medical trainees are involved in errors, events that offer educators important teachable moments about both patient safety and disclosing errors to patients. Trainees are a receptive audience for both informal and formal disclosure education. Teaching trainees how to disclose harmful medical errors to patients will be an important step toward closing the gap between patients' justifiable expectation that harmful errors will be disclosed to them and current practice.

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## Teaching and Learning Moments

### Waiting

With much difficulty, my husband and I decided that I would spend my third year of medical school 200 miles from home. The hands-on experience I would get with the Rural Physician Associate Program would be worth nine months of living separately, though it would be tough on our relationship. I'd married my high school sweetheart during first-year anatomy. Since that time, we focused on my finishing training and becoming a physician above all else, including plans for children. Three months into our separation, in a town of 3,000, I often had periods of loneliness and shed many tears. In the midst of my OB rotation, seeing happy couples cuddling newborns, the separation was even harder. One patient's story jarred me.

April, a teen with three children, initiated prenatal care late in her pregnancy. She was accompanied by an older patient, Patsy, who we knew from an infertility workup. Patsy said, "My husband and I will be adopting the baby." Adoptions were common among pregnant teens in this community, but this appointment was odd. Patsy dominated the conversation, asking detailed questions: "Do the social workers need to be involved? How soon can the baby come home with us?"

Later that month, I was present when April delivered a healthy boy. In the hours following, the nurses informed us, "April said that the father of her child is Patsy's spouse. The conception was done at home with a turkey

baster." This was not mentioned during the prenatal visit, so the OB and I became suspicious and reviewed Patsy's records, learning that Patsy's spouse was aspermic. When we confronted her, she stormed out of the hospital. We spoke with April, who tearfully explained, "They're my neighbors. Patsy told me to say her husband was the father so they could adopt without involving social workers." April still wanted to put her son up for adoption as the child was not her current husband's and she feared for the child's well-being. So we notified the social worker and hospital security, put the baby in a locked room, and phoned the police and state emergency adoption program.

We then learned that Patsy and her husband had previously failed an adoption home inspection and had a police record, having been accused of refusing to return a child to its parents after babysitting.

The adoption program faxed profiles of couples wanting to adopt throughout the morning. April reviewed them and eventually chose a couple with a seven-year-old who had been trying for five years to conceive. They planned to arrive the next morning.

That night the nurses were busy, so I studied for my exam and watched the baby. As I changed and fed him, I reflected on how complicated decisions can be. I thought about my choice to put having a family on hold. It was hard seeing cousins and friends with

new babies, getting pressure from eager grandparents, and explaining time and again why we were choosing to wait. Seeing these three very different families, April, the infertile couple, and the adoptive family, struggle with wanting or not wanting to have a child opened my eyes. Despite the best laid plans, life is unpredictable.

The following morning the adoptive couple arrived, grandparents and car seat in tow. Trying to keep my damp eyes hidden, I helped the OB describe the birth. The adoptive family was excited, teary, and immediately in love with their new son.

Minutes later, I changed out of my scrubs and walked to my car, braving the frigid Minnesota wind. The experience was a fierce reminder of the value of continuity of care and of a doctor's knowledge of her patients. As important was the personal lesson I took from it: there will always be uncertainty about the right time to have a child in my career, but knowing the reward when it finally happens, one way or another, is something I would look forward to.

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